COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

TRANSITION AGE YOUTH (TAY) (16-25)
FULL SERVICE PARTNERSHIP
REFERRAL AND AUTHORIZATION FORM

REFERRAL INFORMATION

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

***Insufficient details may delay referral process**

DMH IS#: _____

DATE: _____ **SSN:** _____

LAST NAME: _____ **FIRST NAME:** _____ **PREFERRED LANGUAGE:** _____

DOB: _____ **AGE:** _____ **RACE/ ETHNICITY** _____ **GENDER:** ☐ **M** ☐ **F** ☐ **UNKNOWN**

CONTACT ADDRESS: _____ **CITY:** _____ **ZIP CODE:** _____

PHONE: _____ **CURRENT LIVING SITUATION:** _____

INSURANCE: ☐ **MEDI-CAL** ☐ **HEALTHY FAMILIES** ☐ **HEALTHY KIDS** ☐ **PRIVATE** ☐ **HWLA** ☐ **NONE**

BENEFITS: ☐ **GR RECIPIENT** ☐ **V.A.** ☐ **SSI** ☐ **SSDI** **OTHER INCOME**

☐ **CLIENT SERVED IN THE MILITARY**

PRIMARY CONTACT: _____ **RELATIONSHIP:** _____

PREFERRED LANGUAGE: _____ **PHONE:** ( ) _____

CONSERVATOR ? ☐ **YES** ☐ **NO** **NAME:** _____ **PHONE:** ( ) _____

REFERRAL SOURCE

Agency: _____ Contact Person: _____

Phone: _____ Fax: _____ E-mail: _____

Is Individual currently receiving mental health services from your agency? ☐ YES ☐ NO

Other Agency Involvement: ☐ DCFS ☐ Probation ☐ DMH ☐ Regional Center Parole: ☐ Revocable* ☐ Non-Recovable

If Individual was referred to any other programs, please identify: _____

☐ Client is aware client has been referred to the FSP Program * Client is not eligible for services

LEVEL OF SERVICE

Individual's Name: _____

DMH IS#: _____

Check ONE ONLY:

☐ Unserved (Not receiving mental health services)
- ☐ History of mental health services, but none currently*
- ☐ No prior mental health services

☐ Underserved (Receiving some MH services, though insufficient to achieve desired outcomes)*
- ☐ FCCS ☐ Outpatient ☐ PEI ☐ Other: _____

☐ Inappropriately served (receiving some MH services, though inappropriate to achieve desired outcomes because of cultural, ethnic, linguistic, physical, or other needs specific to the client)*

*If client has received community-based mental health services within the last 6 months, (1) identify the program(s); (2) indicate the type and frequency of services; and (3) explain why the services are insufficient/inappropriate to achieve desired outcomes:

_____

_____

_____

_____

_____

DIAGNOSTIC CONSIDERATIONS

Primary **DSM-IV-TR Diagnosis**: _____ **Dual Diagnosis** (X Code): _____

Check All that Apply to Individual:

☐ Aggressive Ideation
☐ Aggressive Acts (by history or current)
☐ Aggressive Threats (by history or current)
☐ Fire Setting Ideation or Acts
☐ Inappropriate Sexual Ideation
☐ Inappropriate Sexual Acts
☐ Psychiatrica Hospitalizations (Indicate dates below)
☐ Suicidal Ideation/Attempts
☐ Symptoms of Psychosis
☐ Tarasoff Notifications (past or current)
☐ Other _____

Provide Detail for Any Checked Items:

_____

_____

_____

_____

Fax completed Referral and Authorization Form to **Impact Unit** for your Service Area:

SA 1: Salem Redding	(661) 537-2937	SA 4: Christina Padilla	(213) 680-3225	SA 7: Cheryl Lopez	(213) 384-0729
SA 2: Terica Roberts	(818) 347-8738	SA 5: Jeong Min Rhee	(310) 313-0813	SA 8: Emily Serna	(562) 290-1230
SA 3: Socorro Ramos	(626) 455-4608	SA 6: Perla Cabrera	(213) 427-6166		

FOCAL POPULATION

Individual's Name: _____

DMH IS#: _____

Transition Age Youth must have a Serious Emotional Distubance (SED)* and/or Severe and Persistent Mental Illness (SPMI)**

Indicate TAY FSP Focal Population identified (check all that apply):

1. ☐ Youth aging out of:
   - ☐ Child Mental Health System
   - ☐ Child Welfare System
   - ☐ Juvenile Justice System
2. ☐ Youth leaving Long-term Institutional Care
   - ☐ Level 12-14 Group Homes
   - ☐ Community Treatment Facility (CTF)
   - ☐ Institution of Mental Disease (IMD)
   - ☐ Jail
   - ☐ State Hospital
   - ☐ Probation Camps

   Estimated Discharge Date: _____
3. ☐ Youth experiencing their first psychotic break
4. ☐ Co-Occurring Substance Abuse Disorder **in addition** to meeting at least one (checked) TAY focal population criteria identified above.
5. ☐ Homeless or currently at risk of homelessness
   (Indicate current living situation): _____

☐ Ch Chronically Homeless (HUD Standards)***

Provide Detail for Any Checked Items: _____

_____

_____

_____

_____

* **(SED)** "Seriously emotionally disturbed" means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

(A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

(i) The child is at risk of removal from home or has already been removed from the home.

(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 or Title 1 of the Government Code. [California Welfare and Institutions Code Section 5600.3]

** (**SPMI)** For TAY ages 16-25 may include significant functional impairment in one or more major areas of functioning (e.g., interpersonal relations, emotional, vocational, educational, or self-care) for at least 6 months due to a major mental illness. The individual's functioning is clearly below that which had been achieved before the onset of symptoms. If the disturbance begins in childhood or adolescence, however, there may be a failure to achieve the level of functioning that would have been expected for the individual rather than deterioration in functioning.

***Chronic Homeless HUD**: A person sleeping in a place not meant for human habitation or emergency shelter with a disabling condition who has been continuously homeless for a year or more and/or an individual who has had 4 episodes of homelessness in the past three years.

DISPOSITION

Individual's Name: _____

DMH IS#: _____

TO BE COMPLETED BY SERVICE AREA IMPACT UNIT

DATE RECEIVED: _____

☐ **NOT PRE-AUTHORIZED FOR ENROLLMENT** (Explain reason for decision and plan for linkage to other services):

_____

_____

☐ **PRE-AUTHORIZED FOR ENROLLMENT:**

Name of FSP Agency: _____ Provider # _____

FSP Agency Address: _____ City: _____ ZIP Code _____

Contact Person: _____ Phone: _____

Service Area: _____ Supervisorial District: _____ Fax: _____

Impact Unit Representative: _____ **Date:** _____

(Fax completed Referral and Authorization Form to **Impact Unit** for your Service Area)

TO BE COMPLETED BY FSP AGENCY

FSP AGENCY HAS COMPLETED OUTREACH & ENGAGEMENT AND (Check only one box below):

FIRST FACE TO FACE CONTACT DATE: _____

☐ **REQUESTS AUTHORIZATION TO ENROLL**

☐ **AGENCY DECLINES TO ENROLL, BUT INDIVIDUAL IS ELIGIBLE FOR FSP** (Must complete FSP Appeal Form)

☐ **INDIVIDUAL DOES NOT AGREE TO SERVICES** (Explain reason for decision and plan for linkage to other services)

☐ **IS DEEMED INELIGIBLE FOR FSP SERVICES** (Explain reason for decision and plan for linkage to other services)

_____

_____

FSP Agency Representative: _____ **Date:** _____

☐ **RECEIVED FINAL AUTHORIZATION, BUT INDIVIDUAL NEVER ENROLLED AND/OR NOW DOES NOT AGREE TO SERVICES *AND* NO FSP UNITS OF SERVICE WERE EVER BILLED** (Explain reason for decision and plan for linkage to other services) _____

_____

_____

FSP Agency Representative: _____ **Date:** _____

TO BE COMPLETED BY COUNTYWIDE ADMIN.

☐ **NOT AUTHORIZED FOR ENROLLMENT** (Explain reason for decision): _____

☐ **AUTHORIZED FOR ENROLLMENT**

Countywide Programs Representative: _____ **Date:** _____

PREVIOUS FSP ENROLLMENT WITHIN 365 DAYS ☐ **YES** ☐ **NO** **AGENCY** _____

☐ **AUTHORIZED REFERRAL INACTIVE. INDIVIDUAL NEVER ENROLLED AND NO UNITS OF SERVICE BILLED**

Countywide Programs Representative: _____ **Date:** _____

↓↓TO BE COMPLETED BY SERVICE AREA IMPACT UNIT↓↓

REFERRAL SOURCE NOTIFIED OF DISPOSITION on: _____ by _____

Date Impact Unit Representative